Eastside Sports Rehabilitation Clinic

Personal Information

Patient Name _____ Mr. Ms. Miss Mrs.

Last First Middle

Today's Date: _____ ____

Address _____

Home Phone (_____) _____-_____

_____

Work Phone (_____) _____-_____

City State Zip

Mobile Phone (_____) _____-_____

Birth Date _____

Email _____

By providing your email, you are allowing us to send you email reminders for appointments, our quarterly newsletter, and information about products/services.

Marital Status ____Single ____Married ____Other

Emergency Contact*:*

Name: _____ Phone: _____ Relationship: _____

Nature of Injury/Symptom

Whom may we thank for referring you to this office? _____

Primary Care Physician _____

Date of Injury / Symptom _____ Body Part Involved _____*right or left*

Cause of Injury _____

Billing Information

If Other than Patient, Insurance Subscriber Information:

Patient's Occupation_____

Patient's Employer_____

Employer'sAddress_____

Spouse's Name _____

Spouse's Employer _____

Spouse's Phone _____

Subscriber Name _____

Address _____

_____

Home Phone _____

Work Phone _____

Subscriber's Birth Date _____

Patient Relationship to Insured _____

WE MUST HAVE A COPY OF YOUR INSURANCE CARD ON FILE

Did your injury happen at work? ____ Yes _____ No

Date of Accident _____ Employer at time of Injury _____

Insurance Company _____ Claim Number _____

Insurance Address _____Insurance Phone _____

Were you involved in a motor vehicle accident? _____ Yes _____ No

Date of Accident _____ Insurance Company Name _____

Claim Number _____ Insurance Address _____

Have you seen another physical therapist in the last 90 days? _____ If yes, when was your most recent visit? _____

Assignment and Release: I hereby assign to Eastside Sports Rehabilitation Clinics, PLLC ("ESRC") any and all benefits from any insurer, third party or other protection maintained for my benefit, and authorize and direct that such benefits be paid directly to ESRC for services provided by ESRC. I also authorize the release of any of my health information to any person or entity that is or may be responsible for payment for services rendered by ESRC, including without limitation, insurers and third party payers. I understand that, regardless of insurance coverage, I am responsible for the balance of my account. All accounts are due and payable within 30 days. If I do not pay the balance in full within 30 days of the monthly billing date a finance charge will be added to the account of 1% per month which is an annual percentage rate of 12%. The above information is complete and accurate to the best of my knowledge and I understand and accept the information above.

_____ _____ _____

Signature of Patient *Relationship/ Status if signed by anyone other than the patient* *Date*

EASTSIDE SPORTS
REHABILITATION CLINICS

General Health Questionnaire

Eastside Sports Rehabilitation Clinic

Patient: _____ Age: _____

Diagnosis or Problem Area:_____

Please complete this questionnaire so that we are able to provide you the best possible care. Check any problems below that you have now and/or have had trouble with in the past.

____Chest Pain
____Heart Attack
____High Blood Pressure
____Low Blood Pressure
____Poor Circulation
____Difficulty Breathing
____Tuberculosis
____Respiratory Disease
____Numbness to Hands and Feet
____Head Injury
____Stroke
____Seizures
____Difficulty with Balance
____Frequent Falls
____Blackouts
____Other Orthopedic Injuries

____Osteoarthritis
____Rheumatoid Arthritis
____Hepatitis
____Blood Clots
____Diabetes
____Bleeding/Bruising Easily
____Hearing Impairment
____Visual Impairment
____Skin Rash/Disease
____Severe Night Pain
____Cancer
____Night Sweats
____Osteoporosis
____Bladder Problems
____Surgery Please list:
_____

Do you smoke? _____
Do you exercise? _____ If so, how often? _____
Do you get short of breath with exertion (up/down stairs)? _____
Women, is there any chance of pregnancy?_____
Please list any medications you are taking:_____
_____

List some activities that seem to aggravate your injury/problem area _____
_____

List some activities that seem to relieve your injury/problem area _____
_____

Do you have any other special problems/concerns we should know about?
_____
_____

_____ _____ _____

Patient Signature *Parent / Guardian Signature* *Date*

EASTSIDE SPORTS
REHABILITATION CLINICS

Financial Policy

This is an agreement between Eastside Sports Rehabilitation Clinics (ESRC, PLLC), a Washington Professional Corporation, as creditor, and the Patient/Debtor named on this form.

In this agreement the words "you," "your," and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we," "us," and "our" refer to Eastside Sports Rehabilitation Clinics (ESRC, PLLC).

By executing this agreement, you are agreeing to pay for all services that are received, regardless of insurance coverage.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately each visit you were seen for, the payments made by your insurance company to those dates, any contract adjustments, other adjustments if applicable, copays you have paid, and finance charge, if any. For any balance paid the previous billing cycle, these visits will not appear on future statements.

Payment options if you have no insurance:

1. You choose to pay by cash, check, or credit card on the day that treatment is rendered. The self-pay discount is 35%.
2. If you do not pay at the time services are rendered, you will be charged a finance charge and billed the same day.

Payment options if you have insurance:

1. You choose to pay your deductible of and any out-of-pocket portions at the time services are rendered by cash, check, or credit card. We will then bill your insurance and reimburse you for any credits on the account. 2. You choose to pay all your treatment by cash, check, or credit card. We will request your insurance carrier send their payment directly to you.

Payments: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued and is past due if not paid by the due date on the statement.

Charges to Account: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service.

Contracted Insurances: If we are contracted with your insurance company, we must follow our contract and their requirements. If you have a co-pay or deductible, you must pay that at the time of service. It is the insurance company that makes the final determination of your eligibility. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company.

Finance Charge: A finance charge will be imposed on each item of your account which has not been paid within thirty (30) days of the time the item was added to the account. The **FINANCE CHARGE** will be computed at the rate of one percent (1%) per month or an **ANNUAL PERCENTAGE RATE** of twelve (12%) percent. The finance charge on your account is computed by applying the periodic rate (1%) to the overdue balance of your account. The overdue balance of your account is calculated by taking the balance owed thirty (30) days ago, and then subtracting any payments or credits applied to the account during that time.

Required payments: Any co-payments required by an insurance company must be paid at the time of service. Because this is an insurance requirement, we must receive copays at the beginning of your visit.

Returned checks: There is a fee (currently $25) for any checks returned by the bank.

Past due accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we must refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyer's fees which we incur plus all court costs. In case of suit, you agree the venue shall be in King County, Washington.

Waiver of confidentiality: You understand if this account is submitted to an attorney or collection agency, if we must litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Transferring of Records: You will need to request in writing and pay a reasonable copying fee if you want to have copies of your records sent to another doctor or organization. The amount of the fee is dependent on the number of pages we need to copy. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

Workers Compensation: We require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility. We cannot bill your attorney for charges incurred due to a personal injury case.

Missed Appointments and Late Cancellations: Our therapists value your time and request that you value theirs. Appointments cancelled, and/or rescheduled less than **24 hours prior** to the scheduled appointment time will be charged **$100.00 each**. For Monday appointments, cancellations must be made by **1:00pm on the Friday** prior to your appointment. These charges cannot be billed to your insurance company and will be your responsibility. Missed appointment fees must be paid at the next scheduled appointment. For appointments that are a No-Show without any notice given, the charge will be **$150.00 each**.

Initial to confirm you have read the Late/Cancellation Policy:

Co-signature: If this or another Financial Policy is signed by another person, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

Effective Date: Once you have signed this agreement, you agree to all the terms and conditions contained herein.

Patient Name: _____

Responsible Party (if not the patient): _____

Signature: _____ Date: _____

Cosignature: _____ Date: _____

EASTSIDE SPORTS
REHABILITATION CLINICS

Acknowledgement of Receipt of
Privacy Practices Notice

Eastside Sports Rehabilitation Clinic

I have been presented with a copy of Eastside Sports Rehabilitation Clinic's **Notice of Privacy Practices,** detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

_____

_____

_____ _____

Further, I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Signed: _____ Date: _____

Consent to Leave Messages

We at Eastside Sports Rehab are working hard to ensure that confidentiality regarding your Protected Health Information and treatment is maintained at all times. Due to confidentiality concerns and to comply with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, we require your signature allowing us to leave a message about your upcoming office visit, account information, or any other information you may want us to convey to you via telephone, e-mail or text messaging.

Please complete and sign this form, indicating your preference.

I, _____, give Eastside Sports Rehab permission to:

- ✦ Leave a message, e-mail or text regarding my upcoming office visit, account information, or other pertinent information on my answering machine.

  YES / NO

- ✦ Leave a message, e-mail or text with someone who answers the phone at my residence.

  YES / NO

- ✦ Leave a message, e-mail or text at my place of employment.

  YES / NO

Signed: _____ Date: _____

Notifier(s): Eastside Sports Rehab / ESRC, PLLC

Patient Name: _____

Advance Beneficiary Notice of Noncoverage (ABN)

PAYMENT POLICY:
As a courtesy to you, we will bill your primary insurance company. This treatment may or may not be a covered expense with your insurance policy. Generally, insurance coverage is not 100% for physical therapy. Insurance does not pay for everything, even some care that you or your health provider have good reason to think you need. We do ask that you contact your insurance company regarding your coverage. For your convenience, we accept cash, credit card or personal check.

OPTIONS: **Check only one box. We cannot choose a box for you.**
☐ **OPTION 1.** I want my insurance billed for an official decision on payment. I understand that if they do not pay, I am responsible for payment, but **I can appeal to my insurance.** If they do pay, you will refund any payments I made to you, less co-pays or deductibles.
☐ **OPTION 2.** I do not want to bill my insurance. You may ask to be paid now as I am responsible for payment. **I cannot appeal if my insurance is not billed**.

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits are paid directly to the physical therapist. I am financially responsible for any balance due. I also authorize the physical therapist or insurance company to release any information required for this claim. Signing below means that you have received and understand this notice.

_____ _____

Signature of Patient (or patient's authorized representative) **Date**